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HEALTH CARE FACT.

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CENTERS FOR MEDICARE & MEDICARD SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  (X3) DATE SURVE COMPLETED  (X3) DATE SURVE COMPLETED	DEPART	TMENT OF HEALTH	AND HUMAN SERVICES				FORM AI OMB NO. 0	PPROVED 1938-0391_
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF COLLEGEDALE  STREET ADDRESS, CITY, STATE, ZIP CODE FO BOX 658, 9218 APISON PIKE COLLEGEDALE, TN 37315	STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	A, BUILI	DING	TRUCTION	COMPLETE	<b>≜</b> D
PROVIDER S PLAN OF CORRECTION		RE CENTER OF COL	LEGEDALE		COLLEGE COLLEGE	58, 9210 APISON PIKE EDALE, TN 37315 PROVIDER'S PLAN OF CORREC	TION 1	(X5) COMPLETION
SUMMARY STATEMENT OF DEPICTENCES CON SHOULD BE CON	PREFIX	ACADIS DEGICIENCS	V MI IST RE PRECEDED BY FULL	PREFIX	CRC	EACH CORRECTIVE ACTION SHO DSS-REFERENCED TO THE APPR	OUTD BE 1	DATE
policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by:  2) Residents in the facility have the potential to be affected.  3) Staff received in-services on 12/07/10 regarding immediate intervention and reporting to supervisors according to	F 226	An annual recertific investigation #'s 26 completed at Life Completed at Life Completed to complain 26826 under 42 CF Long Term Care Ficited for complaint 483.13(c) DEVELCABUSE/NEGLECT  The facility must depolicies and process mistreatment, negliand misappropriation.  This REQUIREME by: Based on medical	cation survey and complaint 6262, 26662, 26826, were Care Center of Collegedale on 10. No deficiencies were cited of investigation #'s 26662 and FR Part 482, Requirements for acilities. Deficiencies were investigation #26262.  DP/IMPLMENT TO POLICIES  evelop and implement written dures that prohibit ect, and abuse of residents on of resident property.  NT is not met as evidenced record review, review of a		26	on 7/07/10, for Resident #11 Residents in the facility have the potential to be affect Staff received in-services on 12/07/10 regarding immedia intervention and reporting to supervisors according to	cted.	12-26-10 12-26-10

The findings included:

residents reviewed.

Resident #11 was admitted to the facility on September 10, 2009, with diagnoses including Status Post Vehicle Collision with Sternal Fracture, Right Rib Fracture, Cerebrovascular Accident, Left Hemiparesis, Hypertension, Hypothyroidism, and Sleep Apnea.

observation, and interview, the facility failed to

abuse for one resident (#11) of twenty-six

implement the abuse policy after an allegation of

Medical record review of the Minimum Data Set dated August 22, 2010, revealed the resident had short and long term memory deficits and severely

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X8) DATE TITLE

DON and/or designee will

Report non-compliance to the

DON, Administrator, RSM. ADON, SSD, Pharmacist, FSS,

PI Committee (Medical Director,

ACT Director, ES Director HR Director) monthly to review,

analyze and make recommendations

as needed for three (3) consecutive

months and/or until compliance

is achieved.

Any deficiency statement enging will an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT AND PLAN O	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL.		LDIN	PLE CONSTRUCTION	COMPLE	8/2010	
		445294	B, VVII		70.005	12/0	012010
	ROVIDER OR SUPPLIER			P	REET ADDRESS, CITY, STATE, ZIP CODE PO BOX 658, 9210 APISON PIKE COLLEGEDALE, TN 37315		IVE)
(X4) ID PREFIX TAG	JEROU BORIOTEM	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEPICIENCY)	NILU BE	COMPLETION DATE
F 226	repaired cognitive Review of a facilit Registered Nurse #11 yelling on Jul 4:00 and 5:00 a.r. Continued review revealed RN #3 e observed Certifie and CNA #2 prov		F	226			
,	#1 "hit across re Review of facility Alleged Abuse & protectionSepa the resident(s). I member, send the investigation"	policy Managing Incidents of Neglect revealed "Provide trate the alleged perpetrator from f the perpetrator is a staff the employee home pending December 6, 2010, at 11:55 a.m., dent seated in a wheelchair at		0.00			
	the side of the beautiful the side of the beautiful the side of the beautiful the side of	riew on December 7, 2010, at RN #3 revealed RN #3 heard the and entered the resident's room to aly 3, 2010 at approximately 5:00 interview revealed RN #3 to and CNA #2 providing the to resident #11. Continued the RN #3 then observed CNA #1 is mouth with a disposable the and state to the resident to the interview revealed RN #3 dld confront CNA #1 but returned to on and called the unit manager of Nursing by phone to report the	-	2*			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/04/2011 FORM APPROVED OMB NO. 0938-0391 (X2) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION

NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF COLLEGEDALE  A45294  B. WING  STREET ADDRESS, CITY, STATE, ZIP CO PO BOX 658, 9210 APISON PIKE COLLEGEDALE, TN 37315	ODE  ORRECTION NI SHOULD BE	18/2010
NAME OF PROVIDER OR SUPPLIER.  PO BOX 658, 9210 APISON PIKE  LIFE CARE CENTER OF COLLEGEDALE  COLLEGEDALE, TN 37315	ORRECTION IN SHOULD BE	I va
	N SHOULD BE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CO.  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION	EAPPROPRIATE	COMPLETION DATE
allegation. Continued interview revealed RN #3 had observed CNA #1 and CNA #2 exit the resident's room and at a later time RN #3 returned to the resident's room and observed che resident the resident for injury. Continued interview revealed the resident was sleeping and no injuries were noted to the resident. Interview with RN #3 confirmed RN #3 failed to send CNA #1 home pending investigation of the allegation.  Interview on December 6, 2010, at 3;50 p.m., with the Director of Nursing (DON), in the conference room, revealed CNA #1 was suspended (by telephone, after completing working the 10;00 p.m., to 5:00 a.m., shift) on July 3, 2010, by the DON pending investigation of the allegation. Continued interview with the DON confirmed CNA #1 continued to work and complete the shift after the allegation and confirmed CNA #1 was not immediately sent home after the allegation was made.  C/O #26262  F 281  PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to obtain a physician's order for the administration of oxygen for one resident (#1) of twenty-six residents reviewed.  The findings included:	II annih punti An G	

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (XZ) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING 12/08/2010 B. WING 445294 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER PO BOX 658, 9210 APISON PIKE LIFE CARE CENTER OF COLLEGEDALE COLLEGEDALE, TN 37315 (XS) PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ID PREFIX DATE (X4) ID PREFIX TAG DEFICIENCY) TAG F 281 Continued From page 3 F 281 Physician was notified regarding Resident #1 was admitted to the facility on July Resident #1 on 12/08/10. 12-26-10 16, 2010, with diagnoses including Muscle Weakness, Hypopotassemia, Diabetes Mellitus II, Residents receiving oxygen have 2) Right Bundle Branch Block, Hypertension, the potential to be affected. Abnormal Involuntary Movements, Esophageal 12-26-10 Reflux, and Iron Deficiency Anemia. Nursing staff will audit residents Medical record review of hospital physician orders receiving oxygen to insure that dated November 17, 2010, revealed no orders for physician orders are in place weekly X 4 weeks then monthly oxygen administration. X 2. Nurses received in-service Medcial record review of the physician's orders on obtaining physician orders for December 2010 revealed no physician's order for residents receiving oxygen. 12-26-10 for oxygen administration. DON and/or designee will report Observation on December 6, 2010, at 9:45 a.m., Findings to PI Committee (Medical revealed the resident in bed with oxygen in use at Director, Administrator, DON, 2.5 liters per minute (I/m). Observation on ADON, Pharmacist, FSS, SSD, December 7, 2010, at 9:55 a.m., revealed the ACT Director, RSM, HR Director, resident receiving oxygen at 3 (I/m). Plant Director, ES Director, HIM, Admissions Director) monthly to Interview with the Medical Director on December review, analyze and make 8, 2010, at 6:30 p.m., in the Director of Nursing's recommendations as needed for office, confirmed the hospital orders did not three (3) consecutive months reflect the use of the oxygen and confirmed no and/or until compliance is achieved. 12-26-10 physician orders were given for the use of the oxygen since the resident's return to the nursing home on November 17, 2010. F 323 483,25(h) FREE OF ACCIDENT F 323 HAZARDS/SUPERVISION/DEVICES SS=D The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to

prevent accidents.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S COMPL	ETED	
	ROVIDER OR SUPPLIER	445294	B, WING _	REET ADDRESS, CITY, STATE, ZIP CO		08/2010
	RE CENTER OF COL	LEGEDALE	P	O BOX 658, 9210 APISON PIKE COLLEGEDALE, TN 37315		
(X4) ID PREFIX TAG	VEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	COMPLETION DATE
F 323	by: Based on medical facility investigation the facility failed to place for one resid reviewed.  The findings includ Resident #3 was a December 7, 2009 Osteoporosis, Mus Loss Anemia, Histo Walking.  Medical record rev dated September had no memory de decisions in new si assistance with tra assistance with tra assistance in locor had experienced a  Medical record rev since December 1 was high risk for fa Review of a facility 2010, revealed the wheelchair and dyo wheelchair.  Medical record rev revealed a talking i	record review, review of a n, observation, and interview, ensure safety devices were in ent (#3) of twenty-six residents led:  dmitted to the facility on with diagnosis including scle Weakness, Chronic Blood ory of Fall, and Difficulty liew of the Minimum Data Set 19, 2010, revealed the resident sticits, had difficulty making ituations, required extensive nafers, required limited motion on and off the unit, and fall in the past 31-180 days.	F 323		n bed m was  n and to be by unit opriate se are in cian orders monthly  Il report e (Medical trator, , RSM, Director, Records, review, mendations onsecutive	12-26-10 12-26-10 12-26-10

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DEDVD.	TMENT OF HEALTH	AND HUMAN SERVICES	51		<u> </u>	OMB NO.	0938-0391
CENTE	RS FOR MEDICARE T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/GLIA   IDENTIFICATION NUMBER:	(X2) MU A, BUIL		CONSTRUCTION	(X3) DATE SU COMPLET	
(NO POAN I	or dome-	445294	B. WING			12/08	3/2010
	PROVIDER OR SUPPLIER			PO!	T ADDRESS, CITY, STATE, ZIP CODE BOX 658, 9210 APISON PIKE		
LIFE CA	RE CENTER OF COL	LEGEDALE		CO	PROVIDER'S PLAN OF CORRECT	TION	(X5) COMPLETION
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPY DEFICIENCY)	101.U 6E	DATE
F 323	Continued From pa	age 5	F 3	23			
9	revealed the residence personal safety also Observation on Decrevealed the residence safety alarm in place 7, 2010, at 9:05 a.	ecember 6, 2010, at 12:40 p.m., ent in a wheelchair without the erm or the dycem in place. ecember 6, 2010, at 1:55 p.m., ent in bed without a personal ace. Observation on December m., with the Director of Nursing tent in bed without the personal ace and no dycem or personal ace wheelchair.					
F 33 SS=	December 7, 201 room, confirmed the safety devices unassisted transfe wheelchair. 483.25(m)(1) FRI RATES OF 5% C	Director of Nursing on 0 at 9:05 a.m., in the resident's the facility had failed to ensure is were in place to alert staff of ers and sliding down in the EE OF MEDICATION ERROR OR MORE ensure that it is free of rates of five percent or greater.	F	332			
	by: Based on observ review of manufa interview, the fac						

Medication Error #1:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/04/2011 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X4) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII	DING	CONSTRUCTION	12/0	B/2010
NAME OF PROVIDER OR SUPPL			POF	T ADDRESS, CITY, STATE, ZIP COL BOX 658, 9210 APISON PIKE LEGEDALE, TN 37315	DE	
(X4) ID SUMMAR)	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL. OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE
at the North Wadministered of Diabetes) 1000 #23.  Medical record order dated Derevealed an one (Hydrochloride TABLETTAK WITH BREAKI instructions "  Interview with 14:30 p.m., at the room of Reside error occurred tablet was admisupper and no order. Further be served at 5  Interview with December 7, 2 Service Office were served be December 6, 2 Medication Endows 1000 p. 2 the North Washington of the North	December 6, 2010, at 3:40 p.m., est Split Cart revealed RN #1 me Metformin (medication for mg (milligram) tablet to Resident review of the signed physician cember 1, 2010, for Resident #23 der for " METFORMIN HCL 1000MG (milligram) E 1 TAB (tablet) BY MOUTH FAST" followed by handwritten and supper"  RN.#1 on December 6, 2010, at the North West Split Cart outside the ent #23 confirmed one medication when the Metformin 1000 mg ministered 80 minutes before the with supper per the physician's interview revealed supper would p.m., on the North Wing.  The Food Service Director on 1010, at 4:05 p.m., in the Dietary confirmed North Wing supper trays etween 5:30 p.m., and 5:35 p.m. on 1010.		332	<ol> <li>MD was notified of medicitors on 12/08/10.</li> <li>Residents receiving medication administration administration administration will be conducted weekly Then monthly X 2.</li> <li>DON and/or designed wiffindings to PI Committee Director, Administrator, Pharmacist, FSS, RSM, SES Director, ACT Direct Director, HIM), monthly analyze and make recommandatived.</li> </ol>	cations ffected.  rvice propriate n per n audits y X 4 weeks  If report t (Medical DON, SSD, HR, or, Plant to review, mendations onsecutive	12-26-10 12-26-10 12-26-10

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING B. WING 12/08/2010 445294 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER PO BOX 658, 9210 APISON PIKE LIFE CARE CENTER OF COLLEGEDALE COLLEGEDALE, TN 37315 PROMDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUILL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE PREFIX (X4) IO PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) TAG F 332 Continued From page 7 F 332 prevention of bronchospasm) 21 mcg) per puff. Medical record review of a physician's order dated December 1, 2010, for Resident #23 revealed "...ADVAIR..115-21MCG (microgram) AER (aerosol)...INHALATIONS TAKE 2 PUFFS TWICE DAILY ... ' Review of the manufacturer's specifications in the package insert for Advair oral inhaler revealed ...Instructions for taking a dose from your ADVAIR...After you finish taking this medicine, rinse your mouth with water. Spit out the water. Do not swallow it...Common side effects...include...upper respiratory tract infection...throat irritation..." Review of facility policy How to Use a Metered Dose Inhaler revealed "... Have the resident rinse out his or her mouth and spit out the rinse water..." Interview with RN #1 on December 6, 2010, at 4:30 p.m., at the North West Split Cart outside the room of Resident #23 confirmed one medication error occurred when the resident did not rinse mouth and spit out the rinse water after the administration of the Advair Oral Inhaler. Medication Error #3

20 mg tablet to Resident #24.

Observation on December 7, 2010, at 7:30 a.m., at the North Wing Cart #1 revealed LPN #1 administered one dose of Furosemide (diuretic)

Medical record review of a physician's order dated December 1, 2010, for Resident #24

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DEDART	MENT OF HEALTH	AND HUMAN SERVICES				OMB NO.	0938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES	Toyon	LIL TI	PLE CONSTRUCTION	(X3) DATE SU	RVEY
TATEMENIT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU		32)	COMPLE	
AND PLAN OF	CORRECTION	445294	B, WI			12/08	/2010
		443234		STE	REET ADDRESS, CITY, STATE, ZIP CODE		1
	ROVIDER OR SUPPLIER			l F	O BOX 658, 9210 APISON PIKE		
LIFE CAR	RE CENTER OF COL	LEGEDALE		_	OLLEGEDALE, TN 37315 PROVIDER'S PLAN OF CORRE	CTION	(XE)
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE FRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAC	1X	(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DILLI BE	COMPLETION DATE
F 332	Continued From pa	age 8	F	332	!		
+ 332	revealed an order "FUROSEMIDE. (milliliter)SOLUTIC MOUTH EVERY D	for .,10MG/1ML DNGIVE 3ML (30MG) BY DAY"					
F 074	10:40 a.m. at the fi confirmed one me the wrong dose of administered instead dose ordered by the	#1 on December 7, 2010, at North Wing Nursing Station dication error occurred when Furosemide 20 mg tablet was ead of the Furosemide 30 mg in physician.	F	37	1		
F 371 \$\$=F	STORE/PREPAR	E/SERVE - SANITARY		9			
	considered satisfa	rom sources approved or actory by Federal, State or local actory by federal, State or local					
	i i						
	by: Based on observa	ENT is not met as evidenced ation and interview the facility nt failed to maintain the mixer in and failed to store dietary					
	equipment and for	ood in a sanitary manner.				Σ	
	Observation on D with the Dietary N operation reveals	December 6, 2010, at 10:23 a.m., Manager, of the dish machine in ed fourteen dish racks in contact ront of the dish machine. Further aled a measuring cup and the					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING\_ 12/08/2010 445294 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER PO BOX 658, 9210 APISON PIKE ----

LIFE CARE CENTER OF COLLEGEDALE			COLLEGEDALE, TN 37315				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLÉTION DATE				
F 371	Continued From page 9 cup handle in contact with the rice stored in a bin.	F 371	Dish racks were removed from the floor on 12/06/10. Measuring cup in rice bin was removed on				
	in plastic. Continued observation revealed the miver under side area of the beater arm and the		12/06/10. The mixer was immediately cleaned on 12/06/10.				
	mixer bowl guard had multiple brown and white dried splatters and a white powdery substance present.		Dietary Manager conducted an in-scrvice with dietary staff				
	Interview, with the Dietary Manager, on December 6, 2010 at 10:23 a.m., confirmed the		regarding sanitation on 12/09/10. 12-26-10				
	following:		Dish racks, measuring cups     and mixer will be added to     dietary cleaning schedules.				
	There were fourteen dish racks in contact with the floor in front of the dish machine in operation.		Audits will be conducted Weekly X 4 weeks then monthly X 2 by FSD and/or designee				
	There was a measuring cup and the cup handle in contact with the rice stored in a bin.		To insure compliance.   12-26-10				
F 428 SS=F	3.) The mixer under side area of the beater arm and the mixer bowl guard had multiple brown and white dried splatters and a white powdery substance present. Continued interview revealed the plastic cover over the mixer meant the mixer was clean and ready for use. Further interview confirmed the above items were not maintained in a sanitary manner.  483.60(c) DRUG REGIMEN REVIEW, REPORT	F 428	4) FSS and/or designee will report findings to the PI Committee (Medical Director, DON, ADON, Pharmacist, HR Director, FSS, ES Director, ACT Director, Administrator, Marketing Director, SSD), monthly to review and analyze and make recommendations as needed for three (3) consecutive months and/or until compliance is achieved.  12-26-1				
	The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.						
	The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.						

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 12/08/2010 B. WING 445294 STREET ADDRESS, CITY, STATE, ZIP CODE

	_		444	and a second
NAME	OF	PROVIDER	OR	SUPPLIER

PO BOX 658, 9210 APISON PIKE COLLEGEDALE, TN 37315

## LIFE CARE CENTER OF COLLEGEDALE

LIFE CAL	RE CENTER OF COLLEGEDALE		/	(X4)
(X4) ID PREPIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
F 428		F 428	September and October 2010     Medication Regimen Reviews     with recommendations were     reviewed by Nurse Practitioner	
	This REQUIREMENT is not met as evidenced by: Based on record review individual monthly		and/or MD for any new physician orders.	12-26-10
	medication regimen reviews, facility pharmacy		2) Residents with Medication	

### The findings included:

Record review of the individual (resident) monthly medication regimen reviews completed by the Consultant Pharmacist dated Sepetember 15, 2010, and September 17, 2010, in the Conference Room with the Director of Nursing (DON) revealed 19 of 20 recommendations for the month of September 2010 had not been acted upon. Further record review of the individual monthly medication regimen reviews dated October 20, 2010, revealed 8 of 9 recommendations by the Consultant Pharmacist for the month of October 2010 had not been acted upon.

policy, and interview, the facility failed to act upon

27 of 29 drug regimen reviews completed by the

Consultant Pharmacist for the months of September 2010 and October 2010.

Review of facility pharmacy policy Medication Regimen Review revealed "...PROCEDURE...6. Facility should ensure that Facility Physicians/Prescribers are provided with copies of the MRRs (Medication Regimen Reviews). 7. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR and the Director of Nursing to act upon the

1)	September and October 2010 Medication Regimen Reviews with recommendations were reviewed by Nurse Practitioner
	and/or MD for any new physician
	orders.
2)	Residents with Medication

Regimen Reviews have the

potential to be affected.

- HIM received education on 12/09/10 on process to insure MRR recommendation are reviewed timely with MD and/or NP. DON will audit MRR recommendations within 14 days To insure compliance.
- HIM will report findings to PI Committee (Medical Director, DON, ADON, Administrator, Pharmacist, ACT Director. SSD, FSS, ES Director, RSM, HR Director) monthly to review, analyze and make recommendations as needed for three (3) consecutive months and/or until compliance is achieved.

12-26-10

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/04/2011 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES						OND NO. 0800 000	
ATATEMENT	OF OFFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0.0000000000000000000000000000000000000		E CONSTRUCTION	(X3) DATE SU COMPLE	TED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A, BUI	LDING			
3		445294	B, WIN			12/08	3/2010
NAME OF DE	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE BOX 658, 9210 APISON PIKE		
	RE CENTER OF COLI	LEGEDALE	10		LLEGEDALE, TN 37315		Grand Statement
LIFE CAR				L-	PROVIDER'S PLAN OF CORRECT	TION	(X5)
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREF	PROVIDERS FOUND OF CONTROL OF CON		DULD BE	DATE DATE
F 428	those issues that reintervention, Facility Physician/Prescribution the recommendations provide an explanation of provide the Medical MRRs and should where MRRs requirementation copies of	contained in the MRR. For equire Physician/Prescriber by should encourage er to either (a) accept and act and actions contained within the all or some of the contained in the MRR and action as to why the was rejected. 8. Facility should all Director with a copy of the alert the Medical Director ire follow-up. 9. Facility should MRRs on file in Facility, either dent's permanent medical	F	428			
F 431 SS=D	2:20 p.m., in the Clacility failed to endrug regimen revie Consultant Pharm September 2010 a upon by the attend 483.60(b), (d), (e) LABEL/STORE DITTORE DITTORE DITTORE DITTORE DITTORE CONTROLLED GRAND OF RECORDANT OF RECORDATION OF RECORDANT OF RECORDATION OF RECO	DON on December 8, 2010, at conference Room confirmed the sure 27 of 29 individual monthly lews completed by the acist for the months of and October 2010 were acted ding physician and the DON. DRUG RECORDS, RUGS & BIOLOGICALS employ or obtain the services of acist who establishes a system ipt and disposition of all a sufficient detail to enable an action; and determines that drug er and that an account of all semaintained and periodically cals used in the facility must be appropriated.	F	431			
	labeled in accorda	ance with currently accepted iples, and include the			•		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 12/08/2010 B. WING 445294 STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 658, 9210 APISON PIKE NAME OF PROVIDER OR SUPPLIER COLLEGEDALE, TN 37315 LIFE CARE CENTER OF COLLEGEDALE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (XS) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX DEFICIENCY) TAG F 431 Medication carts were audited on Continued From page 12 F 431 appropriate accessory and cautionary 12/06/10 to insure accurate instructions, and the expiration date when narcotic reconciliation processes. Two (2) refrigerators were replaced applicable. to insure appropriate storage of medications and medications were In accordance with State and Federal laws, the 12-26-10 facility must store all drugs and biologicals in replaced on 12/06/10. locked compartments under proper temperature controls, and permit only authorized personnel to Resident's receiving narcotic have access to the keys. medications have the potential to be affected. Resident's who The facility must provide separately locked, have medications requiring permanently affixed compartments for storage of refrigeration have the potential to 12-26-10 controlled drugs listed in Schedule II of the be affected. Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit Audits of narcotic reconciliation package drug distribution systems in which the Sheets will be conducted by quantity stored is minimal and a missing dose can Unit managers weekly X 4 weeks Then monthly X 2. Nurses will receive be readily detected. In-service by 12/23/10 to ensure Accuracy of the narcotic reconciliation. Weekly audits of medication refrigerators Will be conducted by unit managers This REQUIREMENT is not met as evidenced To insure proper storage of medication. Nurses will receive in-service by 12/23/10 by: Based on observation, record review, facility Regarding notification of any issues 12-26-10 policy, and interview, the facility failed to ensure With storage of medications. an account of all controlled drugs were maintained and periodically reconciled for two (North Wing Cart #1 and North Wing Cart #2) of DON and/or designee will report six medication carts and one (Resident #6) of 26 findings to PI Committee (Medical twenty-six residents reviewed; and drugs were Director, Administrator, RSM, SSD. stored under proper temperature controls for two ADON, Pharmacist, FSS, HR Director, ES Director, ACT Director) of three medication refrigerators. Monthly to review, analyze and make Recommendations as needed for three The findings included: (3) consecutive months and/or until 12-26-10 compliance is achieved. North Wing Cart #1

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 12/08/2010 445294 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER PO BOX 658, 9210 APISON PIKE LIFE CARE CENTER OF COLLEGEDALE COLLEGEDALE, TN 37315 PROVIDER'S PLAN OF CORRECTION COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX PREFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 431 Continued From page 13 F 431 Observation and review of the Individual Patient Narcotic Records with the Director of Nursing (DON) on December 6, 2010, at 11:10 a.m., during the North Wing Cart #1 controlled substance record audit revealed 43 Individual Patient's Controlled Substances Records in the North Wing narcotic notebook and 43 corresponding narcotic medications in the North Wing Cart #1 narcotic box. Further observation of the North Wing Cart #1 December 2010 Narcotic Count Verification Sheet revealed only 42 Individual Patient's Controlled Substances Records were reconciled with 42 corresponding narcotic medications on December 6, 2010, at 6 a.m., by LPN #4 (the incoming nurse on the 6 a.m., to 2 p.m., shift) with RN #2 (the offgoing nurse for the 10 p.m., to 6 a.m., shift). Record review of the North Wing Cart #1 Narcotic Count Verification sheet revealed "... Schedule drugs are to be counted at the beginning and the conclusion of each shift. The incoming nurse and the offgoing (nurse) must count both the number of drugs on each card, and the total number of cards and narcotic sheets... Any discrepancies are to be reported to the DON immediately. Neither associate can leave until count is corrected..." Interview with the DON on December 6, 2010, at 11:15 a.m., at the North Wing Cart #1 confirmed the Narcotic Count Verification Sheet reconciliation by LPN #4 (the incoming nurse on the 6 a.m., to 2 p.m., shift) with RN #2 (the offgoing nurse for the 10 p.m., to 6 a.m., shift) was incorrect on December 6, 2010, at 6:00 a.m., and the discrepancy had not been reported to the

DON.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0	938-0391
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		445294	B, WI	NG _		12/08/	/2010
		445294		STE	REET ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER			r	PO BOX 658, 9210 APISON PIKE		
LIFE CAF	RE CENTER OF COL	LEGEDALE		0	COLLEGEDALE, TN 37315	TON	(45)
	CUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO	ULD DE	COMPLETION DATE
(X4) ID PREFIX	THE PROPERTY OF THE PARTY OF TH	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRE		CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	bille
TAG	REGULATORY OR	LSC IDENTIFY TIME IN			DET (OLD 1)		
5 404	Continued From pa	age 14	F	431	r  -		
F 431	Continued From Se	aye 17					
¥.	187					1	
2	North Wing Cart #	2					
	Observation and review of the Inidividual Patient's						
	Managla Decom M	ith the DON ON DECEMBER Of					
	0040 mt 44-20 a m	during the North Willy want			*		
	1 #2 controlled subs	stance record audit revealed 57 s Controlled Substances					
	Population the No	ith Wing narcotic notebook					
	were reconciled w	ith 57 corresponding narcour					
	madications on De	ecember 6, 2010, at 9 a.m., 4)					
	LPN #3 (the incom	ning nurse on the 6 a.m., to 2 PN #2 (the offgoing nurse for the					
	10 p.m., to 6 a.m.	shift).				7	
	10 p.m., 10 0 d.m.						
		alod one Individual					
	Further observation	on revealed one Individual Record documenting 13 Ativan					
	(madication for ac	ritation) 2 mg (m)  ligram) per m			3		
	1 (milliter) injection	is available for Resident #0.					
	Eurlhar observation	on revealed the corresponding			İ		•
R 	-amontin hav was	count in the North Wing Cart #2 12 Ativan 2 mg per ml injections					
	for Posidont #6	Further review of the Individual			1		
	Patient's Narcotic	Record revealed the beginning			1		
	accept of 20 Africa	n 2 mg ner mi vials (unknown			1		
	date of receipt) no	ad been changed to 19 Ativan 2 prior to the first documentation of					
	use on July 19. 2	010, without an explanation for					
	removing the vial						
			1				
	Intendeur with the	DON on December 6, 2010, at					
}	11:25 a m at the	North Wing Cart #2 confirmed					
!	hun entries for At	IVAN 5 WO DEL UII INTERTIONS MELE	<b>1</b>				
1	missing from the	Individual Patient's Narcotic					

Record for Resident #6 and the Narcotic Count

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES				OMB NO	0938-0391
CENTERS FOR MEDICARE TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION		& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION  A. GUILDING			(X3) DATE SURVEY COMPLETED	
ND ( D III )		445294	B. WI	NG_		12/0	8/2010
	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 658, 9210 APISON PIKE		
LIFE CAP	RE CENTER OF COL	LEGENALE		1	COLLEGEDALE, TN 37315  PROVIDER'S PLAN OF CORRE	CTION	(X5) GOMPLETION
(X4) ID PREFIX TAG	W- ALL DEFICIENCE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREI TAI	FIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	GOMPLETION
F 431	with LPN #2 (the o	reconciliation by LPN #3 (the the 6 a.m., to 2 p.m., shift) (figoing nurse for the 10 p.m., s incorrect on December 6, and the discrepancy had not	F	43			
	medication refrige 10:55 a.m., with the twenty-eight degree observation of the revealed one uno (eye medication for following unopene- medication for Dis-	e temperature in the North Wing rator on December 6, 2010, at the DON revealed a reading of the ses Fahrenheit. Further contents of the refrigerator pened 2.5 ml bottle of Xalatan pened 2.5 ml bottle of Xalatan of Glaucoma) 0.005% and the ed vials of insulin (injection abetes): seven 10 ml vials of this per ml; and three vials of the per ml.					
	Roport revealed t	y Policy Drug Room Inspection he medication refrigerator was between 36 to 46 degrees				for	
	11:00 a.m, in the	DON on December 6, 2010, at North Wing medication room rigerator temperature was too storage of medications.				a	
	medication refrig	e temperature in the South Wing erator on December 6, 2010, at e DON revealed a reading of					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING B. WING\_ 12/08/2010 445294

MAKE OF BOOMDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF COLLEGEDALE			PO BOX 658, 9210 APISON PIKE COLLEGEDALE, TN 37315				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE			
F 431	Continued From page 16 thirty degrees Fahrenheit. Further observation of the contents of the refrigerator revealed one unopened vial of Lantus (medication injection for Diabetes) Insulin 100 units per ml.	F 431					
F 441 SS=D		F 441					
	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.						
	<ul> <li>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;</li> <li>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</li> <li>(3) Maintains a record of incidents and corrective actions related to infections.</li> </ul>		-				
	<ul> <li>(b) Preventing Spread of Infection</li> <li>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</li> <li>(2) The facility must prohibit employees with a communicable disease or Infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</li> <li>(3) The facility must require staff to wash their</li> </ul>						

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES A, BUILDING AND PLAN OF CORRECTION 12/08/2010 B. WING 445294 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER PO BOX 658, 9210 APISON PIKE COLLEGEDALE, TN 37315 LIFE CARE CENTER OF COLLEGEDALE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) GROSS-REFERENCED TO THE APPROPRIATE PREFIX (X4) ID TAG PREFIX DEFICIENCY) TAG F 441 Continued From page 17 F 441 hands after each direct resident contact for which hand washing is indicated by accepted Nebulizer, mask and tracheostomy mask for Resident #3 was placed in professional practice. 12-26-10 plastic bags on 12/06/10. (c) Linens Personnel must handle, store, process and Resident's with physician orders transport linens so as to prevent the spread of for nebulizer treatment, trach and/or oxygen have the potential to be infection. 12-26-10 affected. This REQUIREMENT is not met as evidenced Audits conducted by unit managers Of residents with nebulizer treatments, by: Based on observation and interview the facility Trach and/or oxygen to insure proper failed to store nebulizer tubing and mask, and a Storage in a plastic bag after use Weekly X 4 weeks then monthly X 2. tracheostomy humidifler mask in a sanitary condition for one resident (#3) of twenty-six Nursing staff will receive in-service 12-26-10 By 12/23/10 to insure proper storage. residents records reviewed. The findings included: DON and/or designee will report Observation on December 6, 2010 at 12:27 p.m., findings to PI Committee (Medical revealed a nebulizer on one bad side table and a Director, ADON, Administrator, tracheostomy humidifier machine on a bed side Pharmacist, ES Director, RSM, table, on the opposite side of the bed, of resident SSD, FSS, ACT Director, HR #3. Further observation revealed the nebulizer Director) monthly to review, tubing and mask were in contact with the bed side analyze and make recommendations table and the uncovered nebulizer. Continued as needed for three (3) consecutive observation revealed the tracheostomy humidifier months and/or until compliance 12-26-10 mask was in contact with the bed side table. is achieved. Interview, with Certified Nurse Aide #4 and Licensed Practical Nurse #3, on December 6, 2010, at 12:32 p.m., in the resident's room, confirmed the nebulizer tubing and mask were in contact with the uncovered nebulizer and the bed side table. Continued interview confirmed the tracheostomy humidifier mask was in contact with

the bed side table. Continued interview confirmed

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DEBART	MENT OF HEALTH	AND HUMAN SERVICES				FORM OMB NO.	0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES  (X1) PROVIDER SUPPLIERCLIA					IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAN OF CORRECTION IDENTIFICATION NUMBERS		B. WII		8 <del>************************************</del>			
		445294	1	T	REET ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER	ECEDALE		1	PO BOX 658, 9210 APISON PIKE COLLEGEDALE, TN 37315		
LIFE CAP	RE CENTER OF COL			٠	PROVIDER'S PLAN OF CORRE	CTION	(XS)
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	FIX.	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION
F 441	Continued From pa the the nebulizer to tracheotomy humbo a plastic bag after	ibing and mask, and the differ mask were to be stored in	F	441		3	
	December 6, 2010	istered Nurse (RN) #6, on et 12:35 p.m., in the resident's ne nebulizer tubing and mask, ny humidifier mask were not er use.					
	:	a					